FAQ's: Anthem Blue Cross

Q: How does PPO coverage differ from HMO coverage?

A: HMOs are a more restrictive health care delivery model. HMO members must assign themselves a primary care physician (PCP) who is normally a Family Practitioner, General Practitioner, Internist or Pediatrician. The name of their selected PCP or medical group appears on their ID card. Generally only the PCP can refer or approve the member's access to a medical specialist. HMOs offer more comprehensive coverage levels than PPO plans because of the more restricted access approach. With PPO coverage members do not assign themselves a PCP. Members have unrestricted ability to self refer to specialists with no geographic boundaries. Members receive the highest level of coverage when medical services are received through participating providers. Participating providers have agreed to accept payment amounts set by Anthem Blue Cross for their services. These "allowable amounts" are usually lower than what other physicians and hospitals charge for their services. A member's portion of the charges will also be lower when they use preferred providers. Because of the open access model approach, PPO plans require more out of pocket cost sharing from the members.

Q: What is the difference between PERSCare, PERS Choice and PERS Select?

A: All three are PPO plans. PERSCare offers the highest level of coverage, but at a significantly higher premium cost. PERSCare and PERS Choice offer the full Anthem Blue Cross PPO provider network (i.e. over 55,000 participating California physicians) and over 300 hospitals. PERS Choice has by far the largest enrollment of these three plan options. PERS Select offers the same available benefit coverage as PERS Choice but through a narrower physician network (approximately 30,000) and a tiered hospital network. 176 participating tier 1 hospitals are available for the member to receive the full available benefit coverage. An additional 110 participating tier 2 hospitals are available but the members would receive lesser benefit coverage. PERS Select has the lowest premium costs of all 3 plans.

Q: What is the annual deductible under these plans, how does the deductible work and when does it apply?

A: PERSCare, PERS Choice and PERS Select all feature an annual deductible of $500 per member and $1,000 per family. Several medical services are not subject to this annual deductible. Participating physician office visits are subject to a $20 copayment, annual preventive services are covered at 100%, emergency room services are subject to a $50 copayment and prescription drugs are subject to copayments. For other medical services such as lab tests, imaging, surgeries, behavioral health services, chiropractic services, physical therapy etc., the plan's coverage begins after the $500 annual member deductible (or $1,000 per family) has been met. Once the annual deductible has been met, PERS Choice and PERS Select provide 80% coverage and PERSCare provides 90% coverage.

Q: What is the maximum annual out of pocket costs a member would absorb under PERS Choice?

A: The member would be responsible for office visit copayments, ER services copayments and prescription drugs copayments, the $500 annual deductible and the 20% coinsurance obligation after the deductible has been met. The 20% coinsurance obligation is capped per calendar year at $3,000 per member and $6,000 per family (when using preferred providers). For example, if a PERS Choice member had a catastrophic injury or illness with significant medical costs, the member would be financially liable for the $3,000 maximum (using preferred providers) for the 20% coinsurance, the annual $500 deductible and any applicable copayments for office visits, emergency care and prescription drugs

Q: Why is PERSCare so much more expensive than PERS Choice and PERS Select?

A: PERSCare is the oldest operating plan of the three and has realized a significant enrollment decline over the years. Consequently, the existing PERSCare enrollment is an older population with much higher medical utilization. PERSCare premiums are solely based upon the medical experience of PERSCare enrollment.

Q: What type of coverage is available for members who move outside California?

A: PERS Select is only available to California resident subscribers. PERSCare and PERS Choice provide out of state members with the same benefit coverage they receive in California. The member would use their state's Blue Cross/Blue Shield plan's preferred provider network to receive the highest level of benefit coverage just like they would in California. Most CalPERS retirees who move outside California are enrolled in the PERS Choice plan and their level of plan satisfaction has been very high.

Q: Would a member need to obtain an authorization from Anthem Blue Cross or another physician to seek medical care to a medical specialist?

A: Under these PPO plans no authorization is required. The member has unrestricted freedom to schedule and receive medical services from any licensed provider they select. The highest level of coverage is obtained by accessing preferred providers.

Q: Do PERSCare, PERS Choice and PERS Select provide coverage outside of the country?

A: All three plans provide worldwide coverage including emergency and non-emergency services. Several hundred CalPERS retirees who live outside the country are enrolled in PERS Choice.

Q: How would a member determine if a physician or another health provider is a participating provider with Anthem Blue Cross?

A: Determining if a medical provider is a member of the Anthem Blue Cross preferred network is easy. The member should use the Anthem Blue Cross/CalPERS microsite www.anthem.com/ca/calpers and click the "Find a Doctor" link on the right side of the home page. The member then determines if they want to access medical providers who are participating in either PERSCare/PERS Choice or PERS Select. The member would then follow the prompts. A member can also call the Anthem Blue Cross dedicated CalPERS customer service unit at 877-737-7776.

Q: If I have a family do I have to meet the $1,000 family deductible before my plan starts paying at 80% (PERS Choice and PERS Select) or 90% (PERSCare)?

A: An individual member is subject to a $500 annual deductible before the 80% coinsurance (PERS Choice and PERS Select) or 90% (PERSCare) applies. The annual maximum family deductible amount is $1,000. This family deductible is calculated on an aggregate basis. Medical services that apply to individual family member deductibles are accumulated in the same account. As an example: when four family members each accrue $250 of medical expenses toward their individual deductible the family's annual $1,000 deductible amount will be met. The family deductible application was designed to financially assist families.

FAQ's: CVS Caremark

Q: How long does it take for my prescriptions to arrive by mail?

A: You can expect to receive your prescription approximately 10-14 calendar days after CVS Caremark receives your order. When you need to take your maintenance medications right away, ask your doctor for 2 prescriptions:

- One for up to a 30-day supply, and
- One for up to a 90-day supply, with refills when appropriate.

Have the short-term supply filled immediately at a participating pharmacy and send the 90-day supply prescription to the CVS Caremark Mail Service Pharmacy.

Q: How can I pay for my CVS Caremark Mail Service prescriptions?

A: For credit card payments, simply include your Visa, MasterCard, Discover or American Express number and expiration date in the space provided on the CVS Caremark Mail Service Order Form. You can also pay by check or money order. When ordering online you can also use the Bill Me Later® feature.

Q: Can I obtain my medicine from a non-participating pharmacy?

A: In most instances, you will not need to visit a non-participating pharmacy because there are more than 64,000 participating pharmacies in the CVS Caremark network. If you choose to go to a non-participating pharmacy, you will pay 100% of the prescription price. You may then submit a paper claim form, along with the original receipts to CVS Caremark for reimbursement of covered expenses

Q: How do I change my prescription from a non-participating retail pharmacy to a CVS Caremark participating retail pharmacy?

A: Go to a CVS Caremark participating retail pharmacy and tell the pharmacist where your prescription is on file. The pharmacist will contact the pharmacy and make the transfer for you.

Q: How will I know if my medication is preferred with CVS Caremark?

A: There are 2 ways you can verify if your medication is on the preferred drug list:

- First you can go to www.caremark.com/calpers to "Check Drug Cost". If your medication is not preferred, it will help you with alternatives.

- Another option is to call Customer Care toll-free at 1-877-542-0284. They will be glad to help you look up the medication(s) you are taking and discuss preferred or generic alternatives.

Q: Will the preferred drug list be different than Medco's formulary?

A: Many of the drugs will remain the same, but there will be some differences. Later this year, members who are taking a medication that was preferred in 2011, but will be non-preferred in 2012 will receive a letter in the mail notifying you of the change and the letter will provide you with alternatives to discuss with your doctor.

Q: How do I know if the medication I'm taking needs to be prior authorized next year?

A: A list of medications on the Prior Authorization list will be available on Caremark.com/calpers beginning October 1st, 2011. You can also contact CVS Caremark Customer Care toll-free at 1-877-542-0284 for assistance with looking up your medication.

Q: How do generics help me save money?

A: The U.S. Food & Drug Administration approves generic medications that are clinically equivalent to brand-name medications. Generics generally cost less and are given the lowest copay. For most groups, generics result in at least 70% of all prescriptions filled. You can count on generics because they are safe, effective and provide better value.

Q: If I use the online tool to see what my copay will be in 2012, will it tell me if my medication has a generic alternative, or a preferred alternative?

A: Yes. You can put the name of the drug you are taking into the Check Drug Coverage and Cost Tool and it will provide helpful information on the specific drug you are taking. It will show you what your copay will be, if your drug will be preferred or non-preferred, if there is a preferred alternative and if there is a generic equivalent. It will also show you the cost if you purchase your drug in a 30-day supply at retail or in a 90-day supply at mail service or a CVS/pharmacy.

Q: What is the last date I can use Medco's prescription benefits?

A: Continue to use Medco through December 31st for prescriptions filled at a retail pharmacy. You can begin mailing prescriptions for mail service on December 28th to CVS Caremark so they will arrive at the mail service pharmacy for January 1st. If Medco receives your order to process on or after January 1st, they will forward your order to CVS Caremark, but that could delay the delivery of your order.